

EMT State Examination Waiver / Non-Waiver

EMT Information		
		<input type="checkbox"/> B <input type="checkbox"/> I <input type="checkbox"/> P
Full Name (Print)		
Mailing Address		
City/State/ZipCode		
Home Phone #	Work Phone #	
Social Security #	State Certification #	Certification Exp. Date
Option 1: State Written Examination Waiver		
The EMT is an active member of my In-Service Training Program. I verify that this individual is completely knowledgeable in the didactic requirements of his/her level certification. I authorize this EMT to be waived from the state written examination. I require this EMT to challenge the state practical examination.		
Signature: Medical Control Director / Date		
Option 2: State Practical Examination Waiver		
The EMT is an active member of my In-Service Training Program. I verify that this individual is completely knowledgeable and proficient in the Skills requirements of his/her level certification. I authorize this EMT to be waived from the state practical examination. I require this EMT to challenge the state written examination.		
Signature: Medical Control Director / Date		
Option 3: State Written & Practical Examination Waiver		
The EMT is an active member of my In-Service Training Program. I verify that this individual is completely knowledgeable in the all requirements of his/her level certification. I authorize this EMT to be waived from the state written & practical examination.		
Signature: Medical Control Director / Date		
Option 4: No Waiver Authorized		
The EMT is an active member of my In-Service Training Program, however; I do not authorize the waiver of any portion of the state certification examination. I require this EMT to challenge the state written & practical examinations.		
Signature: Medical Control Director / Date		

EMT Didactic Overview

EMT Name _____

SC EMT Cert. # _____

EMS Provider Name _____

IST Didactic Training Overview			Divisions	Minimum Three Year Hours Required		
Cert. Year 1	Cert. Year 2	Cert. Year 3				
Month/Year	Month/Year	Month/Year				
From:	From:	From:				
To:	To:	To:				
Hours	Hours	Hours	Preparatory	Basic	Intermediate	Paramedic
			<i>EMS Systems: Roles and Responsibilities</i>	6	6	6
			<i>The Well-Being of the Paramedic</i>			
			<i>Injury Prevention</i>			
			<i>Medical / Legal Issues</i>			
			<i>Ethics</i>			
			<i>Overview of Human Systems</i>			
			<i>General Principles of Pathophysiology</i>			
			<i>Pharmacology</i>			
			<i>Venous Access & Medication Administration</i>			
			<i>Therapeutic Communications</i>			
			Total Preparatory Hours			
Hours	Hours	Hours	Airway Management & Ventilation	Basic	Intermediate	Paramedic
			<i>Airway Management & Ventilation</i>	6	6	6
			Total A/W & Vent Hours			
Hours	Hours	Hours	Patient Assessment	Basic	Intermediate	Paramedic
			<i>History Taking</i>	3	0	0
			<i>Techniques of Physical Examination</i>			
			<i>Patient Assessment</i>			
			<i>Clinical Decision Making</i>			
			<i>Communications</i>			
			<i>Documentation</i>			
			Total Pt. Assess. Hours			
Hours	Hours	Hours	Trauma	Basic	Intermediate	Paramedic
			<i>Trauma Systems & Mechanism of Injury</i>	10	10	10
			<i>Hemorrhage & Shock</i>			
			<i>Soft Tissue Trauma</i>			
			<i>Burns</i>			
			<i>Head & Facial Trauma</i>			
			<i>Spinal Trauma</i>			
			<i>Thoracic Trauma</i>			
			<i>Abdominal Trauma</i>			
			<i>Musculoskeletal Trauma</i>			
			Total Trauma Hours			

The training indicated above is verified through signed class rosters.

Primary Training Officer Signature/Date _____

Medical Control Signature/Date _____

EMT Didactic Overview

EMT Name _____

SC EMT Cert. # _____

EMS Provider Name _____

IST Didactic Training Overview			Divisions	Minimum Three Year Hours Required		
Cert. Year 1	Cert. Year 2	Cert. Year 3				
Month/Year	Month/Year	Month/Year				
From:	From:	From:				
To:	To:	To:				
Hours	Hours	Hours	Medical	Basic	Intermediate	Paramedic
			<i>Pulmonary</i>	15	18	18
			<i>Cardiology</i>			
			<i>Neurology</i>			
			<i>Endocrinology</i>			
			<i>Allergies & Anaphylaxis</i>			
			<i>Gastroenterology</i>			
			<i>Urology / Renal</i>			
			<i>Toxicology</i>			
			<i>Hematology</i>			
			<i>Environmental Conditions</i>			
			<i>Infectious & Communicable Diseases</i>			
			<i>Behavioral & Psychiatric Disorders</i>			
			<i>Gynecology</i>			
			<i>Obstetrics</i>			
			Total Medical Hours			
Hours	Hours	Hours	Special Considerations	Basic	Intermediate	Paramedic
			<i>Neonatology</i>	6	6	6
			<i>Pediatrics</i>			
			<i>Geriatrics</i>			
			<i>Abuse & Neglect</i>			
			<i>Patients with Special Challenges</i>			
			<i>Acute Interventions for Home Health Care Pt.</i>			
			Total Sp. Cons. Hours			
Hours	Hours	Hours	Assessment Based - Management	Basic	Intermediate	Paramedic
			<i>Assessment Based - Management</i>	0	0	0
			Total ABM Hours			
Hours	Hours	Hours	Operations	Basic	Intermediate	Paramedic
			<i>Ambulance Operations</i>	2	2	2
			<i>Medical Incident Command</i>			
			<i>Rescue Awareness & Operations</i>			
			<i>Hazardous Materials Incidents</i>			
			<i>Crime Scene Awareness</i>			
			Total Operations Hours			
			Total Program Hours	48	48	48

The training indicated above is verified through signed class rosters.

Primary Training Officer Signature/Date _____

Medical Control Signature/Date _____

EMT Didactic Attendance: Certification Year One

[illegible]

I verify that this individual's didactic training occurred each month as documented above within the guidelines as set forth in the IST Policy. Verification of this training in the form of class attendance rosters are maintained and will be supplied upon request. I understand that providing false, incorrect or misleading information pertaining to an EMT's Recertification may be sufficient grounds for DHEC to take action against the certification of the Primary Training Officer.

Signature: Primary Training Officer / Date

Signature: Medical Control / Date

EMT Didactic Attendance: Certification Year Two

EMT Name	SC EMT Cert. #	EMS Provider Name
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From:		Note: List Months of Training in Chronological Order Based on Certification Year				
To:						
Month	Year	Division	Class Hour #	Topic	IST	Non-IST

I verify that this individual's didactic training occurred each month as documented above within the guidelines as set forth in the IST Policy. Verification of this training in the form of class attendance rosters are maintained and will be supplied upon

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature: Primary Training Officer / Date	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature: Medical Control / Date
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EMT Didactic Attendance: Certification Year Three

[illegible]

I verify that this individual's didactic training occurred each month as documented above within the guidelines as set forth in the IST Policy. Verification of this training in the form of class attendance rosters are maintained and will be supplied upon

Signature: Primary Training Officer / Date

Signature: Medical Control / Date

EMT Skills Verification (Basic)

EMT Name		EMT Cert. #		EMS Provider Name			
Skills	Month	Year	Skills	Month	Year		
1. Patient Assessment/Management			5. Spinal Immobilization				
Medical Trauma			Seated Patients Lying Patients				
2. Ventilatory Management Skills/Knowledge			6. OB/Gynecologic Skills/Knowledge				
Simple Adjuncts Supplemental Oxygen Delivery Bag-Valve-Mask (One-Rescuer) Bag-Valve-Mask (Two-Rescuer) Laryngeal-Mask-Airway (LMA) Oral Suction Orotracheal Intubation Sterile Suction							
3. Cardiac Arrest Management							7. Other Related Skills/Knowledge
Adult 1 & 2 Rescuer CPR Adult Obstructed Airway (Conscious & Unconscious) Child CPR Child Obstructed Airway (Conscious & Unconscious) Infant CPR Infant Obstructed Airway (Conscious & Unconscious) Automated External Defibrillator (AED)							Blood Glucose Monitoring EMT Administered Medications Activated Charcoal Ipecac Instant Glucose EMT Patient Assisted Medications Nitroglycerin Epi Auto-Injectors Prescribed Inhalers IV Maintenance Calculation of Rates Setting Rates DC Procedures Patient Lifting/Stretcher Handling Radio Communications Report Writing & Documentation
4. Hemorrhage Control & Splinting Procedures							
Direct Pressure, Pressure Point, Tourniquet, etc. Pneumatic Anti-Shock Garments Upper & Lower Extremities							

I verify the above individual has demonstrated competency in all skills as listed for the EMT-Basic.

Signature: Primary Training Officer/Date

Signature: Medical Control Physician/ Date

EMT Skills Verification (Intermediate)

EMT Name	EMT Cert. #	EMS Provider Name			
Skills	Month	Year	Skills	Month	Year
1. Patient Assessment/Management			5. IV Therapy Skills		
Medical			Calculation of Rates		
Trauma			Setting Rates		
2. Ventilatory Management Skills/Knowledge			DC Procedures		
Simple Adjuncts			Peripheral		
Supplemental Oxygen Delivery			External Jugular		
Bag-Valve-Mask (One-Rescuer)			Intraosseous		
Bag-Valve-Mask (Two-Rescuer)			6. Spinal Immobilization		
Oral Suction			Seated Patients		
Endotracheal Intubation			Lying Patients		
Nasotracheal Intubation			7. OB/Gynecologic Skills/Knowledge		
Laryngeal-Mask-Airway (LMA)					
Combi-Tube Airway			8. Other Related Skills/Knowledge		
Pharyngeal Tracheal Lumen Airway (PTL)			Blood Glucose Monitoring		
Sterile Suction			EMT Administered Medications		
3. Cardiac Arrest Management			Activated Charcoal		
Adult 1 & 2 Rescuer CPR			Ipecac		
Adult Obstructed Airway (Conscious & Unconscious)			Instant Glucose		
Child CPR			EMT Patient Assisted Medications		
Child Obstructed Airway (Conscious & Unconscious)			Nitroglycerin		
Infant CPR			Epi Auto-Injectors		
Infant Obstructed Airway (Conscious & Unconscious)			Prescribed Inhalers		
Automated External Defibrillator (AED)			Patient Lifting/Stretcher Handling		
4. Hemorrhage Control & Splinting Procedures			Radio Communications		
Direct Pressure, Pressure Point, Tourniquet, etc.			Report Writing & Documentation		
Pneumatic Anti-Shock Garments					
Upper & Lower Extremities					

I verify the above individual has demonstrated competency in all skills as listed for the EMT-Intermediate.

Signature: Primary Training Officer/Date

Signature: Medical Control Physician/ Date

EMT Skills Verification (Paramedic)

EMT Name	EMT Cert. #	EMS Provider Name
Skills	Month	Year
1. Patient Assessment/Management		
Medical		
Trauma		
2. Ventilatory Management Skills/Knowledge		
Simple Adjuncts		
Supplemental Oxygen Delivery		
Bag-Valve-Mask (One-Rescuer)		
Bag-Valve-Mask (Two-Rescuer)		
Oral Suction		
Endotracheal Intubation		
Nasotracheal Intubation		
Laryngeal-Mask-Airway (LMA)		
Combi-Tube Airway		
Pharyngeal Tracheal Lumen Airway (PTL)		
Chest Decompression (Adult & Pediatric)		
Transtacheal Jet Ventilation/Cricothyrotomy		
Sterile Suction		
3. Cardiac Arrest Management		
Adult 1 & 2 Rescuer CPR		
Adult Obstructed Airway (Conscious & Unconscious)		
Child CPR		
Child Obstructed Airway (Conscious & Unconscious)		
Infant CPR		
Infant Obstructed Airway (Conscious & Unconscious)		
EKG Monitoring & Rhythm Identification		
3 Lead & 12 Lead		
Defibrillation		
Cardioversion		
Vagal Maneuvers		
External Pacing		
Managing patients per current ACLS standards		
4. Hemorrhage Control & Splinting Procedures		
Direct Pressure, Pressure Point, Tourniquet, etc.		
Pneumatic Anti-Shock Garments		
Upper & Lower Extremities		
5. IV & Medication Skills/Knowledge		
IV Therapy		
Calculation of Rates		
Setting Rates		
DC Procedures		
Peripheral		
External Jugular		
Intraosseous		
Medication Administration		
Sub-Q Injection		
IM Injection		
IV Push		
IV Drip		
Endotracheal Tube		
Rectal		
Monitoring Approved Inter-Facility Drugs		
6. Spinal Immobilization		
Seated Patients		
Lying Patients		
7. OB/Gynecologic Skills/Knowledge		
8. Other Related Skills/Knowledge		
Blood Glucose Monitoring		
Patient Lifting/Stretcher Handling		
Radio Communications		
Report Writing & Documentation		
Rapid Sequence Induction (RSI) - Optional		

I verify the above individual has demonstrated competency in all skills as listed for the EMT-Paramedic.

Signature: Primary Training Officer/Date

Signature: Medical Control Physician/ Date